

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 7 1957

'57 State File No. 7900

BIRTH NO. _____		REG. DIST. NO. <u>200</u>		PRIMARY REG. DIST. NO. <u>5719</u>		Registrar's No. <u>73</u>	
1. PLACE OF DEATH a. COUNTY <u>Macon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Macon</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Bevier twp.</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural-Bevier twp.</u>			
c. LENGTH OF STAY (In this place) <u>5 mo.</u>				d. STREET ADDRESS (If rural, give location) <u>5 mi. S. of Callao</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>5 mi. S. of Callao</u>							
3. NAME OF DECEASED (Type or Print) a. (First) <u>Hardy</u> b. (Middle) <u>Francis</u> c. (Last) <u>Cross</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 26, 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>		8. DATE OF BIRTH <u>April 20, 1882</u>	
9. AGE (In years last birthday) <u>75</u>		10. MONTHS <u>-</u>		11. DAYS <u>6</u>		12. IF UNDER 1 YEAR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>			
11. BIRTHPLACE (State or foreign country) <u>Callao, Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13a. FATHER'S NAME <u>Louis H. Cross</u>				13b. MOTHER'S MAIDEN NAME <u>Julia F. Denney</u>		14. NAME OF HUSBAND OR WIFE <u>No.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Hugh H. Cross, Callao, Mo.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute exsanguination</u>  ANTECEDENT CAUSES Ascribed conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Spontaneous Hemorrhage into Alimentary tract (acute)</u> DUE TO (c) <u>Carcinoma of pancreas at gallbladder 6 months</u>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Profound jaundice</u>			
19a. DATE OF OPERATION <u>0</u>				19b. MAJOR FINDINGS OF OPERATION <u>none</u>			
20. AUTOPSY? <u>required</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT SUICIDE HOMICIDE <u>none</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>none</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>0</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>0</u>		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>0</u>			
22. I hereby certify that I attended the deceased from <u>Oct. 10, 1956</u> , to <u>April 26, 1957</u> , that I last saw the deceased alive on <u>April 25, 1957</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>William J. Frutas, D.O.</u>				23b. ADDRESS <u>New Cambria Mo</u>		23c. DATE SIGNED <u>4-26-57</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Apr. 28, 1957</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>N.W. of Callao, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>5/5/57</u>		REGISTRAR'S SIGNATURE <u>Rich Mcneely</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Calland</u> ADDRESS <u>New Cambria Mo.</u>			

(Licensed Embalmers' Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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County File No. 6.5779  
Date Filed 6.6.57  
HEALTH DEPARTMENT

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

*R. Lester Brann*

Signed \_\_\_\_\_

Student Embalmer

Licensed Embalmer No. 7472

P. O. Address Marion, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.